Cenpatico
Improving Lives.

FAX DATA REQUEST

School Based Counseling

To:	(Provider Name)	From:	(Cenpatico CC/ICM Name)
Fax:	(Provider fax #)	Fax:	(Cenpatico fax #)
Date:	(Date of request)	Phone:	(Cenpatico phone #)
Re:	(Member name)	Member ID:	(Member ID #)

Dear Provider:

We are requesting documentation of the behavioral health counseling session provided for member, [member's name]. We want to confirm that the counseling session did occur within 7 days following his/her discharge from the hospital and we also require certain additional information to complete our records of the scheduled session. The documentation must clearly indicate whether or not [member's name] was physically present at the counseling session. Please note that we are not requesting therapy notes, and these must not be included in your response.

Please submit the following information:

Provider name: (who held the counseling session): ________________________________

Provider License Type: ____________________________

License #: ____________________________

NPI number (if assigned): ____________________________

Date/Time of service/counseling session:________________

(date)________________(time)

Length of session: ________________ (hours)________________ (minutes)

Was child physically present at this session: YES NO (circle one)

Location/Place of service: (i.e. school office, in home, other) ________________________

Billing code: ____________________________ (we can provide a list of billing codes)

Please return this Fax form to the above named Care Coordinator or Intensive Case Manager at the Fax number shown above **within 10 days** of the counseling session.

If you would like to provide additional information, or if you have any questions, please feel free to contact the member's Care Coordinator/Intensive Case Manager as identified above.

Thank you for your cooperation.